MIHP Design Workgroup Meeting

Dec. 6, 2005

Present: Bonnie (Ayers) Havlicek, Dianna Baker, Lynette Biery, Alethia Carr, Ingrid Davis, Paulette Dobynes Dunbar, Stacey Duncan-Jackson, Sheila Embry, Brenda Fink, Susan Gough, Mary Ludtke, Deb Marciniak, Soleil Nagy, Jackie Prokop, Diane Revitte, Carolynn Rowland, Paul Shaheen, Darlene VanOveren, Jackie Wood, Betty Yancey.

By phone: Sharifa Aboumediene, Ann Bianchi, Jane Chittenden, Patricia Fralick, Judy Fitzgerald, Nancy Heyns, Peggy Vandermeulen.

.

Absent: Mark Bertler, Belinda Bolton, Sandra Brandt, Suzette Burkitt-Wesolek, Sr. Barbara Cline, Sheri Falvay, Ed Kemp, Phyllis Meadows, Sue Moran, Rick Murdock, Doug Paterson, Tom Summerfelt, Betty Tableman, Sharon Wallace.

Tasks

1. Each of us will review and sign the new MIHP Implementation Workgroup (IWG) Memorandum of Agreement (Handout 2), which outlines expectations for IWG members, and send it to Raquel Montalvo, MDCH Division of Family & Community Health, PO Box 30195, Lansing, MI 48933.
2. Paulette will call all of the providers that offer MSS only or ISS only to make sure they understand that they have time to gear up to provide services during pregnancy and infancy, and that DCH will assist them in every possible way.
3. Alethia will invite a DHS representative to serve on the MIHP Data Systems Workgroup to link MIHP and CPS/foster care data.
4. Lynette will ask the MSU person who did the comprehensive lit review on developmental screening tools for data on ASQ sensitivity (how often it accurately identifies children suspected to be at risk for a developmental disorder) and specificity (how often it accurately rules out children not at risk).
5. Ingrid will ask Raquel Montalvo to email a notice when the Postnatal Risk Screener (infant screener) is posted on the MIHP web site, so we can get it out to our networks.
6. MIHP IWG members will send feedback on the infant screener to Deb by Dec. 23.
7. MIHP IWG members will send feedback on the *MIHP Summary of MIHP Stratification Criteria, Interventions, Measures by Domain and Associated Data Sources* (matrix) to Stacey or Deb by Dec. 23.
8. The MIHP Steering Committee will identify time frames for starting three new workgroups: Medical Home, MIHP-DHS-Early On Coordination, and Educational Packets for All Pregnant Medicaid Beneficiaries.

Evolving Role of the MIHP Design Workgroup

Brenda congratulated the DWG for reaching a major milestone – we have "designed" the MIHP and are now in the implementation phase. She thanked everyone for their hard work and invited us to have a piece of the "thank you" cake that Ingrid brought for us. Given our move into implementation, the DWG agreed to the following changes:

1. We will change our name to the MIHP Implementation Workgroup (IWG).
2. We will meet every other month, rather than monthly, on the following dates:
   Tuesday, Feb 14
   Wednesday, Apr 12
   Thursday, Jun 15
   Friday, Aug 11
   Thursday, Oct 12
   Tuesday, Dec 5
3. Each of us will review and sign the new MIHP Implementation Workgroup Memorandum of Agreement (Handout 2), which outlines expectations for IWG members, and send it to Raquel Montalvo.

Brenda reminded us that we are part of the IWG because we bring expertise to the table and represent a particular constituent group. She said that she hopes all of us will remain as IWG members, although she understands if some chose to resign now that the basic design has been framed.

In FY 06, the Institute for Health Care Studies (IHCS) will continue its work to help inform the implementation process, and DCH will work on all aspects of implementation, including the data system and reimbursement. The MIHP Steering Committee will continue with various subcommittees that will bring their products to the IWG. The subcommittees are internal now, but more people will be added as the work continues. Right now, a small internal group is pulling together information to bring to a larger reimbursement subcommittee

Expectations for MIHP and WIC Providers Regarding MIHP Implementation as of Dec. 1, 2005

MIHP. Paulette reported that MIHP was pulled out of the accreditation process this year, as the local health departments already know. Also, DCH won't be doing certification visits this year. Rather than monitor the old program, DCH will provide consultation on the new program.

As of Dec. 1, DCH expects MIHP providers to use the new maternal screening tool. The program name change also goes into effect Dec. 1, but we know the transition will take time, and we don't want providers to throw out their forms with the old name. Jackie said that the *Medicaid Provider Manual* will be updated in January with the name change. However, forms that haven't yet gone through policy changes will still have the old program name on them. The name will be changed on each form as it goes through the policy revision process.

Sue Gough asked if MIHP providers in Southeast Michigan who provide MSS only would be grandfathered in, as some hospital boards are planning to close down MSS, rather than expand to provide MIHP services after delivery. Mt. Clemens General has already made this decision in order to "save money." Paulette and Brenda said that MIHP is designed to serve the mother-infant dyad, we don't want to bifurcate the

program again, and all providers will be expected to add the infant component eventually. However, DCH intends to give providers who offer MSS only plenty of time and technical assistance to make the change. Paulette said that there are only a handful of providers offering MSS only and that she will call each one to make sure they understand that they have a great deal of time to make the decision and that DCH will assist them in every possible way. We need to work out what will happen with OB clinic-based programs; subcontracting may be a possibility.

WIC. Alethia said that expectation of WIC providers as of Dec. 1 is that they will at least talk with MIHP providers who contact them about working together to increase MIHP screenings and referrals. DCH will support agencies that already have integrated WIC and MIHP screening. Agencies that want to use the *WIC-MIHP Integrated Maternal Screening Tool* for both programs need to get the pieces in place before DCH approves them as an integration pilot.

MIHP and WIC Maternal Screening Integration Pilots

Alethia said that the first page of the handout titled, *MIHP and WIC Maternal Screening Integration Pilots Provider Requirements*, lists 8 conditions/requirements that providers must meet in order for DCH to approve them as an integration pilot. Fiscal accountability is the biggest concern on the WIC side. WIC can't bill for MIHP screening at this point, so in order to be able to pass an audit, providers must identify the funding sources that will be used to support the staff time to do MIHP screening (e.g., many programs have local dollars going into WIC). DCH is encouraging providers to call Northwest, Benzie-Leelanau, and Grand Traverse Health Departments to learn how they put the pieces in place to ensure accountability, as they have already worked this out in their communities. As additional providers inform DCH how they're ensuring accountability, DCH will pass this information on to other providers.

Brenda said that in the foreseeable future, we don't expect to see WIC and MIHP as one program. WIC is USDA-funded; MIHP is Medicaid-funded, so the likelihood that we can literally make them into one program is low. However, DCH intends that WIC, MIHP and family planning (FP) will be closely linked, as they comprise the three-part strategy for improving infant mortality and morbidity rates in Michigan. (DCH is hoping that the FP waiver will be approved for February 2006 implementation). In some communities, WIC and MIHP may appear to be one program, but in the background, providers must show how the funding streams flow to the different programs.

At our last DWG meeting, several providers said they wanted to use the integrated screener and DCH said okay. However, after further consideration, we realized it's not that simple. Integration needs to be done very thoughtfully, especially with regard to funding and participant consent. The *Provider Requirements* handout forecasts what coordinating agreements between WIC and MIHP will need to look like.

Paul said that the handout is a good protocol for dialogue between WIC and MIHP and asked if there is a similar protocol to encourage dialogue between MIHP and physicians.

Brenda said that this will come in time, as the link to primary care is an important component of MIHP. Jackie Prokop said that the current policy states that MIHP providers are to communicate with physicians, but we don't have a way to regulate this, and we could be more specific about it. Paul said that some physicians reached out, but most didn't even know about MSS/ISS. We offered provider training on this in the past, but providers didn't know enough about it to show up. Paul said that if we appointed an MIHP – Medical Home Workgroup, he could get representatives from Family Practice, ACOG, etc., and we could invite MAHP, independent practice physicians, and others. Brenda said we will put this on the list of workgroups that should be organized soon.

Lynette said that the research requirements for the integration pilots are simple – they just have to consent the women and submit their data to the Michigan Families Medicaid Project (MFMP). Dianna noted that the process to get consent is very simple. The MFMP is meeting with the proposed integration pilot sites this week. After the first of the year, the integration pilots will get to play with the new electronic formats.

Brenda stated that DCH needs written responses to items 1-8 on the *Provider Requirements* handout from all providers who want to integrate WIC and MIHP in any way. Lynette said she thought only providers who want to do the fully-integrated model (one WIC CPA doing both screeners) are being asked to respond to items 1-8. Alethia and Brenda said that DCH would also like to understand other models that are being used, so they want responses to the 8 items regardless of the level of integration. It's important for providers to share this information with DCH, so DCH cab share it with others.

Peggy asked that since only the designated disciplines can get reimbursed for MIHP screening at this point, will WIC nurses and dieticians come on board as MIHP staff and get reimbursed that way? Alethia replied that the tracking issues would have to be worked out by the agencies. Dianna said that Kent Co. is reversing this – they will train MIHP staff to do WIC screening.

Soleil asked if foster parents qualify for MIHP or only biological parents. Paulette said that in the past, if a child was in foster care, he or she qualified for ISS, along with the caretaker (anyone responsible for the child). If the DHS plan is for reunification, we would want the biological mom to be involved in MIHP too. Mary said that it's very important for infants in foster care to be screened. Brenda said that we hope our goal of enrolling moms in MIHP during pregnancy would reduce the need for foster care, but we do need a protocol for coordination between MIHP and DHS workers. DHS has referred to MSS or ISS in past. Pat said they just had an interesting discussion with DHS last week about a pregnant woman in jail who is about to deliver. The jail called DHS, DHS called MIHP, and MIHP said we can't serve her in jail because we don't serve women in the MOMS program. Brenda said it would be good to organize a workgroup to figure out the DHS link.

Mary said that CPS cases have to be referred to Early On, so it's not just the link between MIHP and DHS we need to figure out – it's also the link with Early On. Brenda said

we'll appoint a workgroup on this after the first of the year. We will be looking for workgroup members who can help us link DHS, MIHP, & Early On and perhaps pilot it in some community. Mary said that Grand Traverse and Leelanau /Benzie are served by the same ISD and DHS, but two different health departments cover that area.

Diane Revitte and Alethia said that the MIHP Data Systems Workgroup should also consider the link to foster care, and that DHS should be part of that workgroup.

Draft MIHP Infant Screener

Lynette did a PowerPoint presentation titled, *Screening Tool Development*. Today we're looking at the version of the draft infant screener for 4 month-old infants. There will be several different versions, based on the infant's age, since one of the main purposes of the screener is to identify any developmental concerns. The screener relies heavily on the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE). The ASQ has different questionnaires for 4, 6, 8, 10, and 12 months (and on up through 60 months). The ASQ:SE has different questionnaires for 6 and 12 months, which can be used within 3 months (and on up through 60 months). The questions for infants from 2 weeks to 4 months of age are taken from Bright Futures. The questions on child development for all ages through 12 months will be posted on both the MIHP and Institute for Health Care Studies web sites. The MIHP Steering Committee felt it was important to use the ASQ to be consistent with other early childhood programs in Michigan, including Early On.

Jackie Wood said that the ASQ has a high pass rate, based on her experience with it in the All Students Achieve Program – Parent Involvement in Education (ASAP-PIE). Parents may report that their child can do something that he or she can't actually do. ASAP-PIE used the ASQ to measure impact resulting from the intervention, but it did not work as an evaluation instrument. Jackie said that Vanessa Winborne, State Early On Coordinator, has also voiced concern about using it as an evaluation tool.

Screening, however, is not the same as evaluation – they are very separate issues. Pat said that her program has used the ASQ and also found that it's too easy to pass – it makes parents think that their kids are okay when they really need a referral. Sue said that her program uses it and has found it to be a good screening tool; they do it 3 or 4 times with a family over the course of the infant's first year and it does pick up developmental concerns. Jackie said much depends on the skill level of the person conducting the screening.

Lynette said the ASQ his been well tested, but she did point out to the MIHP Steering Committee that it was originally developed for use by primary care docs who see the child over time. If MIHP screens at 4 months and the infant looks ok, we could follow up at several additional intervals until the child ages out of the MIHP. Lynette will ask the MSU person who did the comprehensive lit review on developmental screening tools for data on ASQ sensitivity (how often it accurately identifies children suspected to be at risk

for a developmental disorder) and specificity (how often it accurately rules out children not at risk).

Can the ASQ be adapted for premature infants? Lynette said that we're talking full term infants - at least 36 weeks - and that preterm infants would need more in-depth assessment. Sue said that her program age-adjusts the ASQ for preterm infants and catches developmental concerns that way. Lynette said she thinks that extremely premature infants need to be seen at developmental assessment clinics – this isn't something MIHP can do. There's a huge body of literature saying that a baby born at 28 weeks needs to be seen by developmental specialists. Pat said that her program refers preterm infants to the ISD, but their families have lots of other issues so MIHP staff do a great deal of care coordination for them, and end up serving as the Early On family services coordinator. MIHP does serve a fair number of preterm infants. A high percentage of preterm infants are in the CSHCS program. Brenda said this may be another specialty area we need to address – perhaps we could require the infant mortality coalition communities to link to MIHP to look at this issue.

Lynette said that the infant screener is a somewhat truncated version of the maternal screener in terms of the domains that are covered. The demographics are the same regardless of the infant's age. The ASQ questions have been re-formatted to look like the screener. The parent is the one who makes the observations. Sue said that her program combines the mom's observations with the worker's observations. There are some cultural issues. The ASQ must be scored, but this is a quick and easy process.

The infant screener questions on alcohol, drug, etc. are similar to those on the maternal screener – they didn't need a lot of changing. There was discussion around the following items on the screener:

1. Question 4.7A. Jackie Wood does presentations on the topic of guns in the home. She said there may be 10 guns in the home, but the woman only knows where one is kept. Perhaps the question should be worded something like: Do you know how many guns are in your home?

2. Question 4.7B. Usually the woman doesn't own the gun. Perhaps the question should be worded something like: Have you talked to the gun owner about gun safety? Rifles aren't as big a risk as hand guns. In some homes, kids are told not to touch loaded guns. Paul wondered if we should ask if the parents have taken gun safety classes. Jackie said that 70% of persons who take gun safety classes don't implement what they learn.

3. Question 2.4A. This question is: Who cares for your baby while you are at work/school? Jackie Wood said we need to ask: How many different caregivers does you baby have? Many families have patchwork child care arrangements with multiple caregivers, plus the turnover rate among child care providers is very high. These situations lead to attachment problems. Poor women are more likely to have multiple caregivers. What can we do about this? Jackie said we can start educating

families about the importance of stable caregivers – families don't even know it's a problem. If the mom has no care and needs it, that's one thing, but if she says I have 10 people, it's as bad as having none. The mom who thinks that anyone will do is a concern. Lynette said this is a global issue for all Medicaid moms – they all need to know about Michigan Community Coordinated Child Care (MI4C) referral service. It was suggested that we need to start families thinking about this during pregnancy. Pat said that she thinks there are several issues that need to be addressed during pregnancy in addition to child care, including feeding, immunizations and family planning. Lynette noted that MIHP programs may want to do some things that aren't addressed on the screener.

4. The maternal screener has a question about previous child death, but the infant screener doesn't. We need to ask this in case the woman was not in MIHP while she was pregnant. Peggy suggested adding it to demographics question 1.5 that asks: Do you have any other children? Jackie Wood said that if we put it in the demographics question, we would want to know if the woman had several kids who are deceased, so we could ask what their ages were. It's appropriate to ask this – we're already asking all kinds of personal questions and women want it to be acknowledged – they may be afraid of experiencing future losses.

5. The screener is missing the questions on child protective services involvement. Lynette will add these and post the revised screener on the IHCS web site within a few days.

Soleil asked: If there's a foster mom, is this screener completed with the biological mom? Sue said that MIHP gets very little history or other info on the birth mom. Foster parents can tell us the general reason why the child was removed (e.g., drugs, alcohol, shaken baby, etc.), but we don't get any details on children in foster care. We ask the foster mom the whole list of ISS assessment questions, but we haven't done the Edinburgh in the past. This is another reason to start an MIHP-DHS group.

Paul said that in our earlier discussion on WIC-MIHP integration, we talked about getting the woman's consent to share her info with the research team. Here we're dealing with getting her consent to share her info with her medical home, but she may not want MIHP to share info on drug use, abuse, etc., with her physician. Paul said that years ago in Early On, they gave the family a list of agencies/providers and they could check off the ones they were will to share info with. Lynette said women can sign a consent form at MIHP and at the physician's office to share info both ways. Brenda said that we need to think through what it really means to coordinate with the medical home, but we're not there yet.

Carolynn said she still thinks we're mixing screening and assessment with this new process. Jackie Prokop replied that our intent is to identify problems.

See Slide 2, Page 2 for the list of proposed community partners to pilot the screener. Omit Mid-Michigan DHD from the list and add Priority Health.

Peggy said she likes the wording and tone of the instrument and that it's well done.

MIHP IWG members should get our feedback on the infant screener to Deb by Dec. 23, and we'll put the comments on the DCH-MIHP web site. The infant screener will be posted on both the DCH-MIHP and IHCS web sites. It was suggested that the two web sites be linked and that we could have address shortcuts. Ingrid will ask Raquel to send us a notice when the screener is posted, so we can get it out to our networks.

MIHP Summary of MIHP Stratification Criteria, Interventions, Measures by Domain, and Associated Data Sources

Stacey reviewed the key aspects of the *MIHP Summary of MIHP Stratification Criteria, Interventions, Measures by Domain and Associated Data Sources*. She noted that we've been working on this matrix for a year and have seen different pieces of it many times before. The matrix ties together the domains, screening process, low and high risk stratification levels, interventions, outcomes, and data sources we'll use to measure the outcomes. We identified some outcomes we really couldn't measure. The interventions (4^{th} column) will drive the care plan. We will need to conduct trainings to ensure that providers understand the relationship between the pieces and how the intervention is driven by the screening results for each domain.

We will measure outcomes in each domain and will be able to say what percentage of the population received a particular intervention. The last page of the matrix (page 11) lists several program evaluation measures in addition to the measures related to each domain. These additional measures include client and provider satisfaction, effectiveness of outreach (% of target population screened), and number of visits. There also could be some kind of measure of how well MIHP coordinates with the medical home.

Stacey noted that when you see the number of visits or contacts suggested in the intervention column for each domain, you need to know that the literature doesn't generally give us this information, so we're making our best estimate, based on what we know. Lynette added that some research-based programs are prescriptive, but not all, and we have to start somewhere.

Carolyn asked where stress is addressed on the matrix. It somehow fell off. If it's added to the Behavioral Health/Depression domain, the negative screen column would have to change. Brenda said this will continue to be a work in progress and we will see it come together over time.

Sue asked for clarification on the statement that a negative screen on nutrition is defined as "Client enrolled in WIC." Does this mean we expect that the client will receive all nutrition counseling through WIC? Lynette said that a year ago we had nutrition counseling being provided by WIC only, but we learned that not all WIC programs have the capacity to do nutritional counseling for all high-risk clients. If your MIHP program is in a county where WIC has the capacity to do it, refer to WIC. If not, MIHP can

provide nutritional counseling. Brenda said that DCH will be reviewing the outcome data and if we see a huge amount of nutrition services being provided by MIHP, we'll have WIC look at this. Diane said she'd like to see a negative screen defined as "Client enrolled in WIC and no nutritional concerns." Lynette said the current definition implies the woman had no need for nutrition counseling per the screening questions. People are confused about this – it was suggested that the wording be changed to make it parallel to the prenatal care item.

Stacey noted that we need to determine what we will offer to women who screen negative on all domains. What educational pieces do all pregnant women enrolled in this program get (e.g., family planning, immunizations, child care/early childhood education referrals info, etc.) regardless of their risk level? It was suggested that a workgroup be appointed to work on this.

This matrix serves as a template for the infant side.

The matrix will be posted on the MIHP web site. (Send items for the MIHP web site to Ingrid.) Initial feedback on the matrix should be sent to Deb or Stacey by Dec. 23. As we get into each domain more fully and look at evidence-based practices, we may change some outcomes and measures. However, the Data System Workgroup needs to start somewhere, and they need our buy-off on the matrix soon. Decisions about the outcomes are also needed to begin to work on the reimbursement rates. When the Reimbursement Workgroup is appointed, Northwest Michigan Health Department has identified a person to nominate for membership.

Quick MIHP Updates

MIHP Data System Workgroup. Alethia reported that the workgroup has met and is working to ensure that we have the right data sources to measure the outcomes for each domain identified on the matrix. At our last meeting, we proposed starting with the prenatal care, nutrition-breastfeeding, smoking cessation, and inter-pregnancy intervals domains. We also identified smaller workgroup to do the nitty-gritty work.

MIHP Depression Workgroup. Mary reported that she and Deb will be organizing the first meeting of workgroup, to take place early next year.

Closing

Brenda reiterated the 3 workgroups that we decided to organize as we talked today: Medical Home, MIHP-DHS-Early On Coordination, and Educational Packets for All Pregnant Medicaid Beneficiaries. The MIHP Steering Committee will identify time frames for starting these new workgroups. As we seek to people the workgroups, we're looking to you to help identify persons with subject matter expertise – not persons who don't understand the issue and just want to learn more about it. The IWG agreed to this.

Paul said that when we get to the discussion on how Medicaid will establish reimbursement rates for the new program, he's hoping they will be based on the public health philosophy, because in the past, Medicaid hasn't paid based on actual costs.

Please turn in or send in your signed MIHP Implementation Workgroup Memorandum of Agreement and evaluation of this meeting.

MIHP IWG Meeting Schedule

Tuesday, Feb 14, 2006
Wednesday, Apr 12, 2006
Thursday, Jun 15, 2006
Friday, Aug 11, 2006
Thursday, Oct 12, 2006
Tuesday, Dec 5, 2006